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(2) The physician provides services to a recipient who is authorized to reside out of state by the Massachusetts Department of Social Services.
(3) The physician practices outside a 50-mile radius of the border of Massachusetts and provides emergency services to a recipient.
(4) The physician practices outside a 50-mile radius of the border of Massachusetts and obtains prior authorization from the Division before providing a nonemergency medical service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the recipient significantly. To request prior authorization, the out-of-state physician or the referring physician must send to the Division a letter detailing the proposed treatment and naming the treatment facility (*see* the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The Division will send copies of its decision to the recipient, the recipient's local welfare office, the physician, and the proposed treatment facility. If the request is approved, the Division will assist in any arrangements needed for transportation and assistance payments.

433.404: Nonreimbursable Circumstances

(A) The Division will not pay a physician for services provided under any of the following circumstances.
(1) The services were furnished by a physician whose contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to recipient care.
(2) The services were furnished by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the recipient's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.
(3) The services were furnished by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.
(4) The services were provided in a state institution by a state-employed physician or physician consultant.
(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The Division will not pay a physician for performing, administering or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the Division will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(C) The Division will not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment).

433.405: Maximum Allowable Fees

(A) The Massachusetts Rate Setting Commission determines the maximum allowable fees for medical, radiology, laboratory, anesthesia, and surgery services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000. Payment for a service shall be the lowest of the following:
(1) the physician's usual and customary fee;
(2) the physician's actual charge submitted; or

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(3) the maximum allowable fee listed in the applicable Rate Setting Commission fee schedule, subject to any fee reductions enacted into law.

(B) The Rate Setting Commission fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

(1) 114.3 CMR 16.00: Surgery and Related Anesthesia Care
(2) 114.3 CMR 17.00: Medical and Related Anesthesia Care
(3) 114.3 CMR 18.00: Radiology
(4) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) A number of services are designated "I.C." (indicating individual consideration) in the service descriptions in Subchapter 6 of the *Physician Manual*. This means that a fee could not be established for all cases. Appropriate payment for an individual consideration service will be determined by the Division's professional advisors from the physician's descriptive report of services furnished. If a report is not submitted, no payment will be made. (See 130 CMR 433.410 for report requirements.)

(B) Determination of the appropriate payment for an individual consideration service shall be in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the recipient's disease, disorder, or disability;
(4) the policies, procedures, and practices of other third-party insurers, both governmental and private; and
(5) any applicable relative-value studies.

433.407: Service Limitations: Medical and Radiology Services

Additional limitations are set forth in 130 CMR 433.413 and 433.436.

(A) Definitions.

(1) Global Fee – the rate of payment for the two components of a medical or radiology service: the professional component and the technical component. (For information on the global fee as it relates specifically to obstetrics, *see* 130 CMR 433.421.)
(2) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(3) Professional Component – the component of a medical or radiology service for interpreting a diagnostic test or image or for performing a procedure.
(4) Technical Component – the component of a medical or radiology service for the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses, excluding the physician's professional component.

(B) Payment of the Global Fee. The Division will pay a physician the global fee for performing a medical or radiology service in his or her office when one of the following conditions is met.

(1) The physician owns or leases the equipment for providing the technical component of the service, provides the technical component of the service (either directly or by employing a technician), and provides the professional component of the service.
(2) The physician provides the professional component of the service and subcontracts with a licensed Medicare-certified entity to provide the technical component of the service either in the physician's office or at a mobile site. Claims for such services must be billed only by the physician providing the professional component of the service. This constitutes a limited exception to 130 CMR 450.301.

(C) Payment for the Professional Component Only. The Division will pay a physician the applicable fee for providing the professional component of a medical or radiology service in his or her office.

433.408: Prior Authorization

Recipients participating in the MassHealth Managed Care program require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124.

(A) Introduction.

(1) For all services not in the lists of service codes and descriptions in Subchapter 6 of the *Physician Manual* and for those services that are designated "P.A." in the service descriptions, the Division requires that the physician obtain prior authorization. No payment will be made for these services unless prior authorization has been obtained from the Division before the delivery of service. The Division will not grant retroactive prior-authorization requests.

(2) A prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as recipient eligibility or resort to health insurance payment.

(B) Requesting Prior Authorization. All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery;

(2) nonemergency services provided to a recipient by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain psychiatry services.

(D) Nonphysician Services Requiring Prior Authorization. Many nonphysician services require prior authorization, and must first be ordered, or have their need substantiated, by a physician before the Division grants such authorization. These services include, but are not limited to, the following:

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(1) transportation;
(2) selected drugs;
(3) home health services;
(4) nursing facility services;
(5) durable medical equipment; and
(6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the recipient's medical record. Payment for maintaining the recipient's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a recipient, that record must set forth the nature, extent, quality, and necessity of care furnished to the recipient. When the information contained in a recipient's medical record is not sufficient to document the service for which payment is claimed by the provider, the Division will disallow payment for the claimed service.

(C) The Division may request, and the physician shall furnish, any and all medical records of recipients corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.205. The Division shall produce, or at its option may require the physician to produce, photocopies of medical records in lieu of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing home, hospital outpatient department, and emergency room services provided to recipients must include the reason for the visit and the data upon which the diagnostic impression or statement of the recipient's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but shall not be limited to, the following:

(a) the recipient's name and date of birth;
(b) the date of each service;
(c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(d) the recipient's medical history;
(e) the diagnosis or chief complaint;
(f) clear indication of all findings, whether positive or negative, on examination;
(g) any medications administered or prescribed, including strength, dosage, and regimen;
(h) a description of any treatment given;
(i) recommendations for additional treatments or consultations, when applicable;
(j) any medical goods or supplies dispensed or prescribed; and
(k) any tests administered and their results.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the recipient's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care furnished to a recipient must be included for each date of service or service code claimed for payment, along with any data that update the recipient's medical course.

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(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record shall be deemed to document services provided to recipients and billed to the Division if it conforms to and satisfies the medical records requirements set forth in 105 CMR 130.000 (Licensure of Hospitals). The physician claiming payment for any hospital inpatient visit service shall be responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical records requirements for radiology, psychiatric, and other services can be found in the applicable sections of 130 CMR 433.000.

(G) Compliance with the medical records requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 shall be determined by a peer-review group designated by the Division as set forth in 130 CMR 450.206. The Division shall refuse to pay or, if payment has been made, shall consider such payment to be an overpayment as defined in 130 CMR 450.234 subject to recovery, for any claim that does not comply with the medical records requirements established or referred to in 130 CMR 433.000. Such medical records requirements shall constitute the standard against which the adequacy of records shall be measured for physician services, as set forth in 130 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment when the service description stipulates "with report only", when the service is designated "I.C." in the service description, or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable professional advisors to assess the extent and nature of the services.

(B) Operative Report. For surgery procedures designated "I.C." (individual consideration), operative notes must accompany the physician's claim. An operative report must state the operation performed, the name of the recipient, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and his assistants, and the technical procedures performed.

433.411: Explanation of Abbreviations in Service Descriptions

The following abbreviations are used in the service descriptions.

(A) (P.A.) indicates that prior authorization is required (*see* 130 CMR 433.408).

(B) (I.C.) indicates that the claim will receive individual consideration to determine payment (*see* 130 CMR 433.406).

(C) (I.P.) indicates that the service is an independent procedure (*see* 130 CMR 433.401(P); for surgery procedures, *see* also 130 CMR 433.452(F)).

(D) (S.O.) indicates that a second opinion is required in most cases (*see* 130 CMR 433.453).

433.412: Office Visits: Introduction

The office visits listed in Subchapter 6 of the *Physician Manual* are of three types: adult, pediatric, and family planning. The distinction is made for administrative purposes only; fees for all three types of visits are the same.

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(A) Adult Office Visits. The adult office visit service codes and descriptions in Subchapter 6 of the *Physician Manual* apply only when the physician provides services other than family planning to recipients 21 years of age or older.

(B) Pediatric Office Visits. The pediatric office visit service codes and descriptions in Subchapter 6 of the *Physician Manual* apply only when the physician provides services other than family planning to recipients under 21 years of age. (For information on other services for children, *see* 130 CMR 433.484 through 433.495.)

(C) Family Planning Office Visits. Regardless of the recipient's age, the service codes in Subchapter 6 of the *Physician Manual* must be used when the primary purpose of an office visit is family planning. (*See* 130 CMR 433.455 through 433.458 for regulations concerning abortion and sterilization.) The Division will pay for only those family planning supplies and medications listed in Subchapter 6 of the *Physician Manual*, at the physician's acquisition cost.

433.413: Office Visits: Service Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per recipient per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure to the same recipient on the same date when the office visit and the treatment/procedure are performed in the same location. This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (*see* 130 CMR 450.140 *et seq.*); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. Certain diagnostic tests may be billed for in addition to an office visit. X rays and laboratory tests may be billed with an office visit.

(C) Obstetric Care. The Division offers the following two methods of reimbursement for prenatal and postpartum office visits.

(1) Fee for Service. The fee-for-service method requires submission of claims for services as they are performed. Prenatal and postpartum visits are billed by using the applicable adult or pediatric office visit codes. Fee for service is always available for reimbursable obstetric services.

(2) Global Fee. The global fee method offers two options, the standard global fee and the enhanced global fee (*see* 130 CMR 433.422 and 433.423). Both are available only when the conditions in 130 CMR 433.421 are met.

(D) Immunization or Injection. If the primary purpose of an office visit is an immunization or injection, the visit must be billed for as a minimal service visit (Service Code 9001, 9011, or 9031). The cost of the injectable material is also reimbursable if it is not distributed free of charge by the Massachusetts Department of Public Health and if its cost to the physician is more than $1.00. (*See* 130 CMR 433.440 on drugs dispensed in a physician's office.) (For allergy serums, *see* 130 CMR 433.427.)

433.414: Hospital Emergency Room, Outpatient Department, and Courtesy Room Visits

(A) Emergency Room Treatment. The Division will pay a physician for medical care provided in a hospital emergency room only when the hospital's claim does not include a charge for the physician's services.

(B) Emergency Room Screening Fee. The Division will pay a physician for a screening performed in a hospital emergency room to determine the level of care required by a recipient's condition only if the recipient being screened is enrolled with a Primary Care Clinician and:

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(1) the level of care is determined to be elective; or
(2) between the hours of 8:00 A.M. and 7:59 P.M., the level of care is determined to be urgent and the recipient's PCC denies authorization.

(C) Outpatient Department and Courtesy Room Visits. The Division will pay a physician for medical care provided in a hospital outpatient department or courtesy room only when the hospital's claim does not include a charge for the physician's services. The Division will pay 50% of the maximum allowable fee for the service.

(D) Billing. The office visit service codes and descriptions in Subchapter 6 of the *Physician Manual* apply to hospital emergency room, outpatient department, and courtesy room visits.

433.415: Hospital Services: Service Limitations and Screening Requirements

(A) Mental Health and Substance Abuse Admissions. The Division will pay for mental health and substance abuse services provided in an acute or nonacute inpatient setting only if the admitting provider has satisfied the screening program requirements at 130 CMR 450.125. Appendix D of the *Physician Manual* contains the name, address, and telephone number of the contact organization for the screening program.

(B) Hospital inpatient visit fees apply to visits by physicians to recipients hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per recipient for the length of the recipient's hospitalization.

(C) Visits to recipients who have undergone or who are expected to undergo surgery are not reimbursable, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, visits to such recipients are reimbursable (Service Code 9075).

(D) Payment will be made only to the attending physician, with the following exceptions.
(1) A consultation is reimbursable (*see* 130 CMR 433.418 for regulations concerning consultations).
(2) If it is necessary for a physician other than the attending physician to treat a hospitalized recipient, the other physician's services are reimbursable (Service Code 9082, concomitant care). An explanation of the necessity of such visits must be attached to the claim form. The Division's Medical Advisor will review the claim and determine appropriate payment to the other physician.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The Division seeks to ensure that a Medical Assistance recipient receives nursing facility services only when available alternatives (*See* 130 CMR 433.476 through 433.483) do not meet the recipient's need, and that every recipient receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.251 through 456.253.

(B) Service Limitations. Payment for a visit by a physician to recipients in nursing facilties or rest homes is limited to one visit per recipient per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a recipient's home is limited to one visit per recipient per day. (For information on additional home health services reimbursable under the Medical Assistance Program, see 130 CMR 433.478.)

433.418: Consultations: Service Limitations

Only one comprehensive consultation per recipient per case episode is reimbursable. Additional consultation visits per episode must be billed as follow-up consultations.

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433.419: Certified Nurse-Midwife Services

(A) (Reserved)

(B) Reimbursable and Nonreimbursable Services.

(1) Certified nurse-midwife services concerning the care of women throughout the course of pregnancy, labor, and delivery periods, and care to mothers and their infants in the post-partum period, as well as gynecological and family planning services are reimbursable under the following conditions.

(a) The services must be limited to the scope of practice authorized by state law or regulation pertaining to certified nurse-midwives.

(b) The nurse-midwife must meet the educational and certification requirements mandated by state law or regulation.

(c) The nurse-midwife must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.

(2) Reimbursement is available for intrapartum services immediately prior to delivery to recipients who are experiencing unanticipated medical complications that result in cesarean sections or complicated vaginal deliveries that require the services of a physician. This service is not reimbursable when the nurse-midwife bills for the delivery, whether on a fee-for-service or global fee basis.

(3) Childbirth education classes are not reimbursable.

(4) Only those surgical services specified in the Nurse-Midwife Services section in Subchapter 6 of the *Physician Manual* are reimbursable.

(C) Requirements for Participation.

(1) The nurse-midwife must meet the educational and certification requirements mandated by state law or regulation.

(2) The nurse-midwife must enter into a formal collaborative arrangement with a physician or group of physicians, as required by state law or regulation, for referral and consultation in the event of medical complications. The collaborating physician must be a Medical Assistance provider and must engage in the same type of clinical practice as the nurse-midwife.

(3) If the graduate nurse-midwife misses a scheduled national certification examination or fails to pass the examination, the graduate nurse-midwife must immediately cease providing services to recipients, in accordance with state regulations.

(4) After the nurse-midwife passes the scheduled certification examination, the nurse-midwife must obtain authorization to practice in an expanded role from the Board of Registration in Nursing.

(5) If the nurse-midwife's license or authorization to practice in an expanded role as a certified nurse-midwife expires or is suspended, the nurse-midwife must immediately cease providing services to recipients.

(D) Salaried Nurse-Midwives.

(1) When a nurse-midwife is a salaried employee of a physician or group practice, such employment shall satisfy the requirement for a collaborative arrangement.

(a) The employer must ensure that the nurse-midwife complies with the requirements in 130 CMR 433.419(C).

(b) Only the employer may submit claims for the services provided by the nurse-midwife. (This is an exception to 130 CMR 450.301.)

(i) Such claims are submitted using only the service codes appropriate to nurse-midwife services, in accordance with Subchapter 6 of the *Physician Manual*.

(ii) Only one claim for each service may be submitted. (Consultation between a salaried nurse-midwife and a salaried nurse-midwife's employer does not constitute a service.)

(2) Services provided by a nurse-midwife who is a salaried employee of a hospital or other facility are not reimbursable as discrete fee-for-service items; such services are reimbursable only as components of the hospital's or facility's Medical Assistance rate.

(3) A salaried nurse-midwife may not participate in the Medical Assistance Program as an independent practitioner.

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(E) Nonsalaried Nurse-Midwives.

(1) In addition to meeting the requirements of 130 CMR 433.419(C), a nonsalaried nurse-midwife must submit to the Division a copy of the license issued by the Board of Registration in Nursing showing authorization to practice as a nurse in an expanded role as a certified nurse-midwife, and must notify the Division in writing within two weeks of a failure to take or pass the national certification examination or of the expiration or suspension of the license or authorization to practice in an expanded role as a nurse-midwife.

(2) To be eligible for payment by the Division, a nonsalaried nurse-midwife must have a Medical Assistance provider number. The application for a provider number must include the name and the provider number of all collaborating physicians. Whenever the nurse- midwife enters into a collaborative arrangement with a physician other than those indicated on the application or changes the address shown on the application, the Division must be notified in writing within two weeks after the change. Notification of a new collaborative arrangement must include the signatures of both the nurse-midwife and the new collaborating physician.

433.420: Obstetric Services: Introduction

The Department offers two methods of reimbursement for obstetric services: the fee-for-service method and the global fee method. Fee for service requires submission of claims for services as they are performed and is always available to a provider for all reimbursable obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met. Global fee offers two options: the standard global fee and the enhanced global fee.

433.421: Obstetric Services: Global Fee Method of Reimbursement

(A) Definition of Global Fee. The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The two global fee options (standard global fee and enhanced global fee) are available only when the conditions in 130 CMR 433.421 are met. The two options are fully defined in 130 CMR 433.422 and 433.423.

(B) Eligible Recipients. The Division will pay a standard global fee or enhanced global fee for obstetric services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Conditions for Global Fee.

(1) A physician or independent nurse-midwife who assumes responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and postpartum care for the recipient is the primary provider. In a group practice or when a back-up physician is involved, the primary provider is not required to perform all the components of a global delivery directly. Another member of the practice or a back-up physician can perform services; he or she is a referred provider. Only providers in the same group practice or back-up physicians are considered referred providers. These referred services must not be billed for separately; they will be reimbursed as part of the global fee.

(2) Only the primary provider may claim payment of the global fee. A physician who is a primary provider may claim payment of the global fee for the obstetric services provided by a nurse, nurse practitioner, nurse-midwife, or physician assistant in his or her employ. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).) All global fee claims must use the delivery date as the date of service.

(3) All of the components of a global fee must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

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(D) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same recipient, the following conditions apply.

(1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and postpartum care) are provided directly by the primary provider, by a nurse, nurse practitioner, nurse-midwife, or physician assistant in his employ, or by a referred provider, that is, a member of the same group practice or a back-up physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)

(2) If the primary provider bills for the global fee, no referred provider may claim payment from the Division. Payment of the global fee constitutes payment in full both to the primary provider and each referred provider.

(3) If the primary provider bills for the global fee, any provider who is not a referred provider but who performed prenatal visits or postpartum visits for the recipient may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no other provider may claim payment for the delivery.

(4) If the primary provider bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same recipient.

(E) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a standard or enhanced global fee; this includes services performed by referred providers or employees of the primary provider. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each global fee recipient's record in a way that allows for easy review of her obstetrical history.

433.422: Obstetric Services: Standard Global Fee

The standard global fee is an all-inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The physician or independent nurse-midwife must perform or coordinate a minimum of six prenatal visits, the delivery, and postpartum care to claim the standard global fee.

(A) For a physician, the global fee includes payment for the delivery (Caesarean or pelvic), all prenatal visits, and one postpartum visit.

(B) For an independent nurse-midwife, the global fee includes payment for the delivery (pelvic only), all prenatal visits, and one postpartum visit.

433.423: Obstetric Services: Enhanced Global Fee

The enhanced global fee includes all the components of the standard global fee (a minimum of six prenatal visits, the delivery, and postpartum care), and requires three additional categories of service as a condition for payment. These three categories are coordinated medical management; health-care counseling; and obstetrical-risk assessment and monitoring. The primary provider must develop a plan of care, documented in the recipient's medical record, for each enhanced global delivery recipient; the plan of care must include services in each category that are relevant to the recipient's condition.

(A) Coordinated Medical Management. The physician and nurse, nurse practitioner, nurse-midwife, or physician assistant employed by the physician, or an independent nurse-midwife must provide referral to and coordination of the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

(1) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;

(2) coordination of medical management with necessary referral to other medical specialties and dental services; and

(3) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

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(B) Health-Care Counseling. In conjunction with providing prenatal care, the physician and nurse, nurse practitioner, physician assistant, or nurse-midwife employed by the physician, or the independent nurse-midwife will be required to provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:

(1) PGH screening for teenage pregnant women;
(2) smoking and substance abuse;
(3) hygiene and nutrition during pregnancy;
(4) care of breasts and plans for infant feeding;
(5) obstetrical anesthesia and analgesia;
(6) the physiology of labor and the delivery process, including detection of signs of early labor;
(7) plans for transportation to the hospital;
(8) plans for assistance in the home during the postpartum period;
(9) plans for pediatric care for the infant; and
(10) family planning.

(C) Obstetrical-Risk Assessment and Monitoring. The physician and nurse, nurse practitioner, physician assistant, or nurse-midwife employed by the physician, or the independent nurse-midwife must manage the recipient's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services will be reimbursed separately and should be billed for on a fee-for-service basis. Such services may include, but are not limited to, the following:

(1) counseling specific to high-risk patients (for example, antepartum genetic counseling);
(2) evaluation and testing (for example, amniocentesis); and
(3) specialized care (for example, treatment of premature labor).

433.424: Obstetric Services: Fee-for-Service Method of Reimbursement

The fee-for-service method of reimbursement is always available to a provider for obstetric services reimbursable under the Medical Assistance Program. If the global fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the Division only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the recipient, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the recipient may claim payment only on a fee-for-service basis.

(C) When an independent nurse-midwife is the primary provider and a Caesarean section is performed by the collaborating physician, the independent nurse-midwife may claim payment for the prenatal visits only on a fee-for-service basis, using the service codes and descriptions in Subchapter 6 of the *Physician Manual*. The collaborating physician may claim payment for the Caesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services: Service Limitations

The comprehensive and routine follow-up eye examinations in Subchapter 6 of the *Physician Manual* are reimbursable, subject to the following limitations.

433.425: continued

(A) Prior authorization from the Division is required for a comprehensive eye examination (Service Code 9300) if the service has been furnished:

(1) within the preceding 12 months, for a recipient under 21 years of age; or

(2) within the preceding 24 months, for a recipient 21 years of age or older.

(B) The services designated "I.P." in the ophthalmology service descriptions in Subchapter 6 of the *Physician Manual* are reimbursable only if performed independently of a comprehensive eye examination (Service Code 9300).

(C) Titmus vision test (Service Code 9347) or a similar screening device is reimbursable only once per year per recipient.

(D) Eyeglasses and other ophthalmic materials, with the exception of over-the-counter items such as magnifiers, may be dispensed only upon prescription, even if the prescriber dispensed the materials himself. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to fill the prescription. The prescriber must provide the recipient with a signed copy of the prescription without extra charge. The date or dates upon which the prescription is filled or refilled must be recorded on the recipient's copy of the prescription. (For further regulations concerning ophthalmic materials, *see* 130 CMR 402.000s.)

433.426: Audiology Services: Service Limitations

(A) Audiology services are reimbursable only when provided by a physician or by an audiologist certified by the American Speech and Hearing Association and employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only (Service Code 9350).

(B) Only physicians who have been approved by and received written authorization from the Division to perform hearing aid evaluations (Service Code 9367) will be paid for such services.

(C) The Division will pay for hearing aids only when the hearing aid evaluation is performed by an approved provider and only if prior authorization has been obtained.

433.427: Allergy Testing: Service Limitations

(A) The service codes and descriptions in Subchapter 6 of the *Physician Manual* apply to allergy testing performed by a physician or under a physician's direct supervision. All fees include payment for physician observation and interpretation of the tests in relation to the recipient's history and physical examination. A physician may bill for an initial consultation (*see* Service Codes 9152 and 9153 in Subchapter 6 of the *Physician Manual*) in addition to allergy testing.

(B) Blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation may not be claimed more than three times annually per recipient.

(C) Immunotherapy and desensitization (extracts) are reimbursable up to $84.00 annually per recipient (*see* Service Code 9800 in Subchapter 6 of the *Physician Manual*). The amount and anticipated duration of the supply must be listed on the claim form.

(D) Follow-up office visits for injections and re-evaluation are reimbursable as office visits (*see* Subchapter 6 of the *Physician Manual*).

(E) All sensitivity tests listed in Subchapter 6 of the *Physician Manual* are for one recipient during one year regardless of the type of tests performed or the number of visits required.

433.428: Psychiatry Services: Introduction

(A) Eligible Recipients. The Division pays for the psychiatric services described in 130 CMR 433.429 when provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111. (For other reimbursable mental health services *see* 130 CMR 433.472.)

(B) Reimbursable Services. The Division pays for the psychiatry services described in 130 CMR 433.429.

(C) Nonreimbursable Services.

(1) Nonphysician Services. The Division will not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.

(2) Research and Experimental Treatment. The Division will not pay a physician for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a recipient's clinical need.

(3) Nonmedical Services. The Division will not pay a physician for nonmedical services, including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is reimbursable);

(d) street worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The Division will not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other nonreimbursable services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The Division will not pay for psychological testing provided by a physician.

(D) Recordkeeping (Medical Records) Requirements. Psychiatric medical records must be in compliance with the Division's general recordkeeping requirements (*see* 130 CMR 433.409). In addition, the following specific information must be included in the medical record for each recipient receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;
(2) the recipient's diagnosis;
(3) the recipient's medical history;
(4) the recipient's social and occupational history;
(5) the treatment plan;
(6) the physician's short- and long-range goals for the recipient;
(7) the recipient's response to treatment; and
(8) if applicable, a copy of the signed consent for electroconvulsive therapy.

(E) Frequency of Treatment. The Division will pay a physician for only one session of each type of service provided to a recipient in one week except for crisis intervention, as discussed below.

(1) In a crisis, as defined in 130 CMR 433.429(K), the Division will pay a physician for extra sessions. The physician must bill for these services using the service code for crisis intervention and must document the following in the recipient's record:

(a) the recipient is in a state of marked life change or crisis;
(b) the recipient's ability to function is likely to deteriorate; and